Republic of Zambia
Ministry of Health

Analysis of Behaviour Change Communication Materials in Selected Districts of Zambia

March 2013

Analysis of Behaviour Change Communication Materials in Selected Districts of Zambia

March 2013
This publication was produced for review by the United States Agency for International Development. It was prepared by the Zambia Integrated Systems Strengthening Program.

Table of Contents

List of Tables and Figures

Acknowledgements

This study was conducted by the Institute of Economic and Social Research (INESOR) at the University of Zambia.

Special thanks go to Zambia Integrated Systems Strengthening Programme (ZISSP) for giving us the opportunity to carry out this assignment. Gratitude also goes to Ministry of Health at all levels and all ministry stakeholders, without whose support this study could not have been completed. Lastly, appreciation goes to the research participants for their cooperation and especially for providing the valuable information which informed this study.

Research Team

An interdisciplinary team from the Institute of Economic and Social Research conducted this study.

Principal Investigator	Professor Mubiana Macwan'gi
Co-Principal Investigators	Bernard Phiri, Sr. Rose Nyondo
Data Managers	Genovive Ozichi, Moyern Mungwala
Data entry Clerks	Salanji Nzima, Betty Kakumbi, Namulula Munalula
Field Supervisors	Tedson Simwanza, Joseph Tembo
Research Assistants	Jones Tachila, Tabo Mulonda, Ngombo Kalimbwe, Chinyama Hachilala, Charles Kalimalwendo, Chisenga Yenga, Mwenya Mulenga, Christine Nambobe.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CATF	Community AIDS Task Force
CIDRZ	Centre for Infectious Disease Research in Zambia
DATF	District AIDS Task Force
DHMT	District Health Management Team
DHOs	District Health Offices
DVD	Digital Video Discs
FGD	Focus Group Discussion
FP/RH	Family Planning/Reproductive Health
HBC	Home-based Care
HC	Health Centre
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
IEC	Information, Education and Communication
ITN	Insecticide-Treated Net
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
NAC	National AIDS Commission
NGO	Non-Governmental Organisation
NHC	Neighbourhood Health Committee
PHO	Provincial Health Office
PMTCT	Prevention of Mother to Child Transmission (of HIV)
SFH	Society for Family Health
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
ZANIS	Zambian News and Information Services
ZISSP	Zambia Integrated Systems Strengthening Program

Executive Summary

Introduction

The Zambia Integrated Systems Strengthening Programme (ZISSP) conducted an inventory of existing behaviour change communication (BCC) materials at the provincial, district and community levels to provide insight on existing gaps, to guide programming and to inform the development of a community BCC strategy. This study had the following five objectives:

- To identify and document BCC materials in five thematic areas: HIV/AIDS, family planning/reproductive health (FP/RH), malaria, maternal, newborn and child health (MNCH) and nutrition
- To assess the availability and distribution systems of BCC materials at district, health centre (HC) and community levels
- To identify the main actors providing BCC materials at the district and community levels
- To determine the accessibility of BCC materials to Neighbourhood Health Committees (NHCs) and how effectively the NHCs used the materials
- To identify the strengths and weaknesses in utilisation of available BCC materials

Methodology

This was a cross sectional study conducted between March and May 2012. Data were collected in three provinces of Zambia: Eastern, Lusaka and Western. Two districts were purposively selected from each of the three provinces: Luangwa, Chongwe, Lundazi, Mambwe, Kalabo and Lukulu. The study collected both qualitative and quantitative data.

Key Findings

Following are the study's key findings. The findings are organised by sub-theme, which align generally with the study objectives.

Availability of BCC Materials

- Most BCC materials are print materials.
- Most of the print materials are in poster form and are produced in English.
- Print materials are not available at the community level. Community members reported that they mainly see BCC materials when they visit health facilities to seek care for themselves or their children.
- Most BCC materials are on HIV/AIDS; very few are on other health topics, such as nutrition, malaria and non-communicable diseases, that are perceived to be major problems at the HC and community level.

Target Audience

- Current BCC materials target the most affected population groups, such as women and youth.
- There are few BCC materials targeting men.
- Some BCC materials use characters depicting urban situations and/or people, which target audiences in rural areas do not identify with.

Preferred Channels of Communication

The most preferred channels of communication among rural communities in the study are drama and radio; however, both of these channels have very limited coverage. Drama groups do not perform regularly and are limited to central places such as markets and clinics. Use of radio is impeded by lack of power (electricity/batteries) and weak signals in areas distant from the broadcasting station. Other, less commonly used channels of information dissemination preferred by the community are the following:

- Door-to-door visits by community health workers and other community volunteers
- Social events, i.e. football matches, youth games, church meetings and formal and informal group meetings, like drinking establishments for men
- Work places such as schools and clinics
- Community group discussions
- Community mobilisation and sensitisation

Distribution Mechanism

- The current distribution system from the HC to the community is not systematic, regular or institutionalised.
- The distribution system is dependent on NHC members (volunteers) who have limited capacity, especially transport, to collect the materials from HCs for use as training tools and/or distribution to the community.
- Inequities in the supply and distribution of BCC materials exist. Most of the available BCC materials were found in Lusaka; few were found in the rural communities.
- There is inadequate transport at the district and HC levels to ensure the distribution of available BCC materials. This is compounded by long distances to collection points, hence hindering access to and utilisation of BCC print materials.

Stakeholders/Community Involvement

- Thirty partners were found to be involved in the production and distribution of BCC materials in this study.
- International NGOs are more active in the production and distribution of BCC materials than local NGOs.
- In general, rural communities are not involved in the identification of priority issues, design, and pretesting of BCC materials.

NHCs

- NHCs reportedly conduct most of the community sensitisation on health issues.
- Active participation of NHC members is challenged by a lack of training, transport, incentives, and allowances during field work.
- Some communities do not have established NHCs and some NHCs are not active.

Recommendations

The following recommendations are based on study findings and ensuing discussion.

Availability of BCC Materials

- The government, in collaboration with its partners, should develop a plan to review the current production and distribution of BCC materials with the objective of developing a comprehensive BCC strategy to ensure adequate and consistent availability of BCC materials at all levels, including the community.
- BCC materials on other health areas, such as FP/RH, nutrition and malaria, as well as non-communicable diseases, and epidemic-prone diseases such as cholera, should be developed and disseminated.

Design and Implementation of BCC Materials

Overall proper monitoring of the design, development, implementation and evaluation of the effectiveness of all BCC materials and activities should be conducted. More specific recommendations on this topic are listed below.

Target Audience

- Print materials should be improved by using appropriate persons with characteristics that are relevant to the intended audience.
- To complement current BCC materials, which focus primarily on women and youth, new BCC materials should be designed that consider all relevant target audiences, including men and other influential groups.
- To ensure that all target audiences are most effectively reached, the materials development process should include a comprehensive audience segmentation and analysis process.
- The process of developing BCC materials must include adequate pretesting for effective message delivery to all intended audiences.

Language Used in BCC Materials

- New BCC materials should be produced in local languages and low literacy formats to more effectively reach more audiences.

Communication Channels

There is a need to explore ways to increase the use of communication channels that extend beyond posters, particularly within these rural communities. This could include:

- Strengthening the capacity of drama groups and institutionalizing the approach, thereby supporting the groups to improve community level outreach and encourage community level ownership of BCC programmes and commitment to behavioural change.

- Facilitating and institutionalizing the strengthening and expansion of interpersonal communication interventions and interactive community programmes like community, school and church meetings.
- Exploring the use of social media and cell phones for health communication.

Distribution Mechanism

- The government, with the support from partners, should develop a system for ensuring equitable geographical and population-based distribution of BCC materials in all districts, including a feedback loop.
- To address the issue of transportation for NHCs to help distribute materials, other intermediate means of transport such as bicycles should be provided for NHCs.
- To help reduce the misuse of BCC materials within the community, the government and its partners should develop and implement interventions to educate the community about the proper use and value of BCC materials.

Stakeholders Involvement

- The government and its partners should strengthen the coordination and monitoring of BCC activities at all levels.
- To help ensure sustainability of BCC efforts, local NGO capacity to develop and implement BCC activities should be strengthened.
- Effective systems for actively engaging the community in the design and distribution of BCC materials should be developed.
- The government should put in place a mechanism indicating which rural districts need partner support for BCC efforts and what type of support is required.
- The government and other stakeholders should consider training and deploying BCC specialists in all the districts to improve BCC programming at the district and community levels.

Strengthening NHC Involvement

- NHCs should be provided with BCC materials for distribution to their communities.
- There is a need to conduct training for NHCs to effectively use BCC materials.

1. Introduction

The Zambia Integrated Systems Strengthening Programme (ZISSP) is a USAID-funded programme that has been designed to increase use of high-impact health services through a health systems strengthening approach. ZISSP supports the Ministry of Health (MOH) to strengthen national, provincial, district and community level health systems and operates in 27 districts selected from the nine provinces of Zambia (Table 1).

Table 1: ZISSP Districts by Province

Province	District
Central Province	Serenje, Mkushi and Kapiri-Mposhi districts
Copperbelt Province	Lufwanyama, Masaiti and Luanshya districts
Eastern Province	Nyimba, Lundazi and Mambwe districts
Luapula Province	Mansa, Nchelenge and Chiengi districts
Lusaka Province	Chongwe and Luangwa districts
Northern Province	Mpika, Chilubi, Mbala and Nakonde districts
North-Western Province	Mwinilunga, Zambezi and Solwezi districts
Southern Province	Kalomo, Sinazongwe and Gwembe districts
Western Province	Lukulu, Shang'ombo and Kalabo districts.

ZISSP focuses on high impact behaviour change communication (BCC) interventions in the areas of HIV/AIDS, family planning and reproductive health (FP/RH), malaria, maternal, newborn and child health (MNCH) and nutrition. ZISSP conducted an inventory of existing BCC materials at the provincial, district and community levels to provide insight on existing gaps, to guide programming and to inform the development of a community BCC strategy.

The specific objectives of the study were:

- To identify and document BCC materials in five thematic areas: HIV/AIDS, FP/RH, malaria, MNCH and nutrition
- To assess the availability and distribution systems of BCC materials at the district, health centre (HC) and community levels
- To identify the main actors providing BCC materials at the district and community levels
- To determine the accessibility of BCC materials to Neighbourhood Health Committees (NHCs) and how effectively they used them
- To identify the strengths and weaknesses in utilisation of available BCC materials

2. Methodology

2.1 Study Sites and Sampling Procedures

This was a cross sectional study conducted between March and May 2012. Data were collected in six rural districts located in three provinces. To select the study districts, the nine provinces in Zambia were placed into three clusters. The first cluster comprised urban provinces (Lusaka and Copperbelt), the second cluster comprised least economically developed provinces (Eastern, Southern, Luapula and Central), and the third cluster consisted of hard-to-reach provinces (Western, Northern and North Western). From each cluster two districts were selected, as shown in Table 2.

Table 2: Study Sites

Province	District	Health Centre
Lusaka – Urban	Chongwe	Chainda Chalimbana
	Luangwa	Luangwa Mpuka
Eastern – Least economically developed	Lundazi	Lundazi Urban Lusuntha
	Mambwe	Chikowa Masumba
Western – Rural and hard to reach	Kalabo	Birkenstock Liumba
	Lukulu	Lubosi Simakumba
3	**6**	**12**

The total sample for this study was 404 participants. Thirty-eight key informants participated in the in-depth interviews (IDIs), while 366 participants (176 females and 190 males) participated in focus group discussions (FGDs). The FGD participants consisted of 168 NHC members and 198 ordinary community members. The study employed a multistage sampling approach at provincial, district and community levels. At provincial and district levels, key informants were purposively selected from the Provincial Health Office (PHO) and relevant District Health Management Teams (DHMTs) for participation in IDIs. Selection criteria included having knowledgeable about BCC programmes in the province/district and/or being a focal point person in the five thematic areas under study. This generally included health promotion officers, BCC focal point persons, health information officers, malaria focal point persons, HIV/AIDS focal point persons, and nutrition and MNCH coordinators.

To identify HC and community level participants for the study, two HCs were purposively sampled from each district; one within five kilometres of the district health office (DHO) and one approximately 30 to 40 km away from the DHO and located in a more remote area. This was done to have a wider representation of the sample. Thereafter, two NHCs, one with easy access (under 5 kilometres) to the HC and the other 5 km to 15 km away from the HC, were systematically selected in consultation with the health centre staff. This was done to ensure that there was an equal representation in the catchment areas. From each selected NHC, about 10 NHC members were identified to participate in FGDs. In addition, at least nine ordinary community members were also identified from each of the 12 NHC catchment areas in the study to participate in the FGDs. Both the NHC members and the ordinary community members were

purposively selected based on availability. A summary of the IDIs and FGDs that were conducted is provided in Appendix 1.

2.2 Data Collection Methods

Multiple and complementary qualitative data collection tools were used. These included IDI and FGD guides (Appendices 2-4), and a check list for collecting BCC materials (Appendix 5).

2.2.1 In-Depth Interviews

Trained interviewers conducted IDIs with focal point persons responsible for the distribution of BCC materials, such as HIV/AIDs focal point persons, environmental health technologists, malaria focal point persons and health officers in charge of MNCH, family planning and nutrition. These interviews were conducted at the district and provincial level. IDIs were also conducted with BCC stakeholders in Lusaka, including donors, implementing partners, and non-governmental organisations (NGOs). Appendix 6 has a complete list of BCC stakeholders, their roles, their strengths and the challenges they face. The information collected during these IDIs included strengths and gaps of BCC materials, as well as availability, storage, distribution mechanism, and utilisation of the materials. Other information included the ability of NHCs to access and use BCC materials, effectiveness of the NHCs to use available BCC materials, gender perspective, and producers of BCC materials. The IDI guide can be found in Appendix 2.

2.2.2 Focus Group Discussions

To elicit common views in the community about BCC materials and approaches, FGDs were conducted with the NHCs and the community members in the HC catchment areas. Information collected covered a) availability of, distribution mechanism for and access to BCC materials, b) stakeholders involved in producing BCC materials, drama and health community radio programs, c) strengths and gaps of BCC materials, and d) factors affecting utilisation of available BCC materials, particularly among NHCs. The FGD guides can be found in Appendices 3 and 4. FGDs in Lusaka and Eastern provinces were conducted in Nyanja while in Western Province they were conducted in Lozi.

2.2.3 Review of BCC Materials

A documentation guide (see Appendix 5) was also used to collect information on available BCC materials from various sources which included the six DHOs, the HCs, and other institutions involved in the production and distribution of BCC materials. In addition, BCC materials were collected during IDIs conducted in the three provincial districts (Chipata, Lusaka and Mongu), as shown in Appendix 1. BCC materials were collected in the five thematic areas, HIV/AIDS, FP/RH, nutrition, MNCH and malaria. For each material collected the following was reviewed: title, topic (content), format, language, audience, producer and contact information.

2.3 Informed Consent

All participants gave informed consent for their participation in the study. The interviewer or FGD facilitator ensured that the study was explained to the participants before each discussion could take place and gave them information sheets about the study (see Appendix 7). Participants also signed informed consent forms (see Appendix 8) to demonstrate their willingness to be a part of the study. The IDIs and FGDs were audio recorded, for which the participants also gave their consent. In addition to a facilitator, each FGD had a note taker who took notes of the discussion verbatim. Participants were provided with refreshments during the FGDs.

2.4 Data Management and Analysis

Data from the FGDs and IDIs were captured in notes and on tapes and digital recorders. Before being transcribed, data from FGDs were translated from the local language to English. Transcription was done by two transcribers who had not taken part in the data collection process. This allowed for objectivity in the transcription process. To ensure quality, the transcripts were further edited by two field supervisors from the data collection team, and all errors they found were corrected before final analysis.

After transcription, data analysis was conducted. First the text was coded and then read by four researchers in order to extract key emerging themes. The data were later divided further based on the codes developed to yield the findings.

3. Results

This section outlines the key results of the study in line with the objectives.

3.1 Types of BCC Materials Available

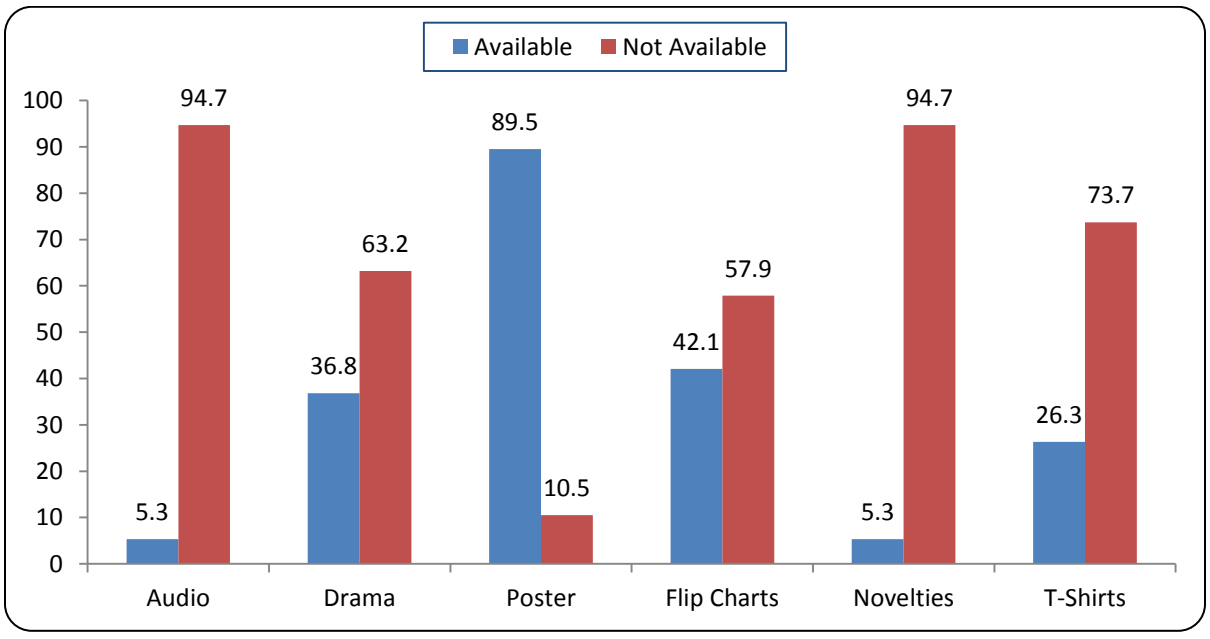
Several types of BCC materials/methods used to disseminate health messages were identified in the study sites. These include a) print materials, b) drama, c) electronic media, including radio, public address systems, DVDs, and CDs and d) interpersonal communication.

3.1.1 BCC Materials Available, by Location

All participants were asked about the availability of BCC materials in the community, and at HCs, and DHOs. They reported that the majority of the BCC materials available at the community and district level are print materials, specifically posters and leaflets. Some community members reported that magazines are found at HCs and schools. In addition, NHCs reported using discussion cards/flip charts to sensitise the community on positive health seeking behaviour.

Figure 1 shows the different types of BCC materials/approaches that focal point persons reported to be available at DHOs. Almost 90 percent reported posters to be available; 42 percent reported flip charts. Novelty items such as branded t-shirts, caps, pens, and mugs were generally not available although limited quantities distributed during special health events were reported at the DHMT and HC level.

Figure 1: Types of BCC Materials Available at DHO Level Reported by Focal Point Persons (N=19)



3.1.2 Usefulness of BCC Materials

In general, BCC materials were reported by FGD participants and key informants to be relevant and useful in addressing key public health issues. NHC members reported that the BCC materials were very useful when educating the community. The BCC focal point persons also reported that sensitisation through the use of BCC materials increased the uptake of health services such as voluntary counselling and testing (VCT), FP/RH and child immunisation. A BCC focal point person from Chongwe explained that the radio/TV spots and posters found at HCs, *"Contributed significantly in the use of health services by the community"*. In Kalabo, a female NHC FGD participant said, *"All of the materials that we receive have been of great help to the community, although I emphasise that the materials that we receive here are very few and take a long time to reach us"*.

3.2 Description of BCC Materials by Type

This section presents study findings on BCC materials organised by material types.

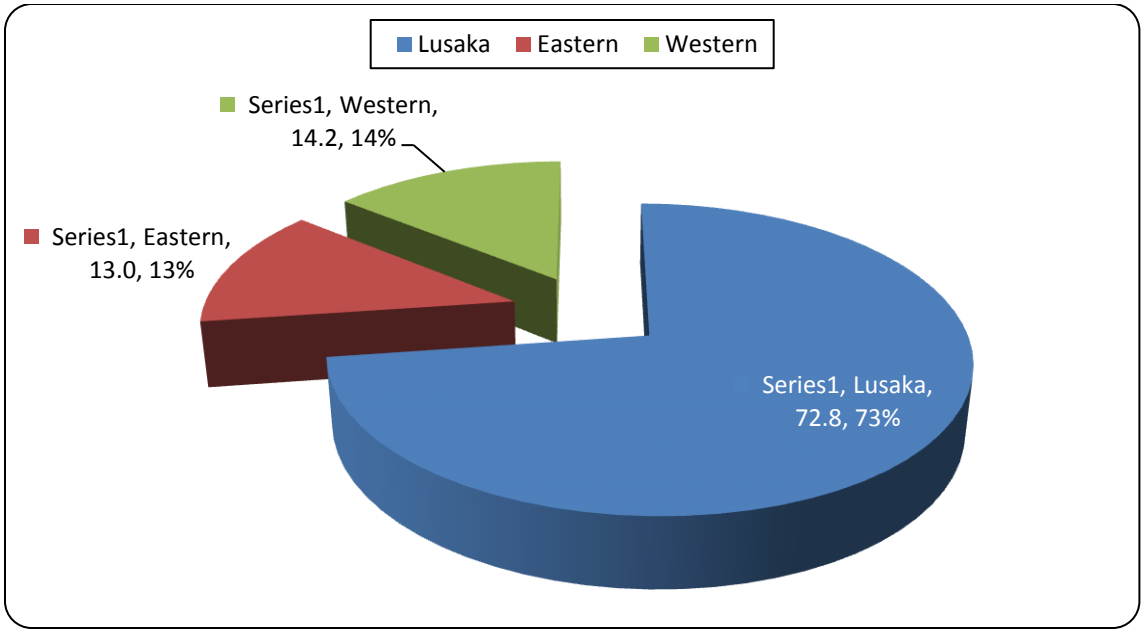
3.2.1 Print Materials

3.2.1.1 Coverage of Print Materials

i) Coverage by Province

The study found that print materials are not evenly distributed to provinces, as shown in Figure 2. Almost 73 percent of all the 261 print materials found were in Lusaka province. Eastern and Western provinces each had slightly less than 15 percent.

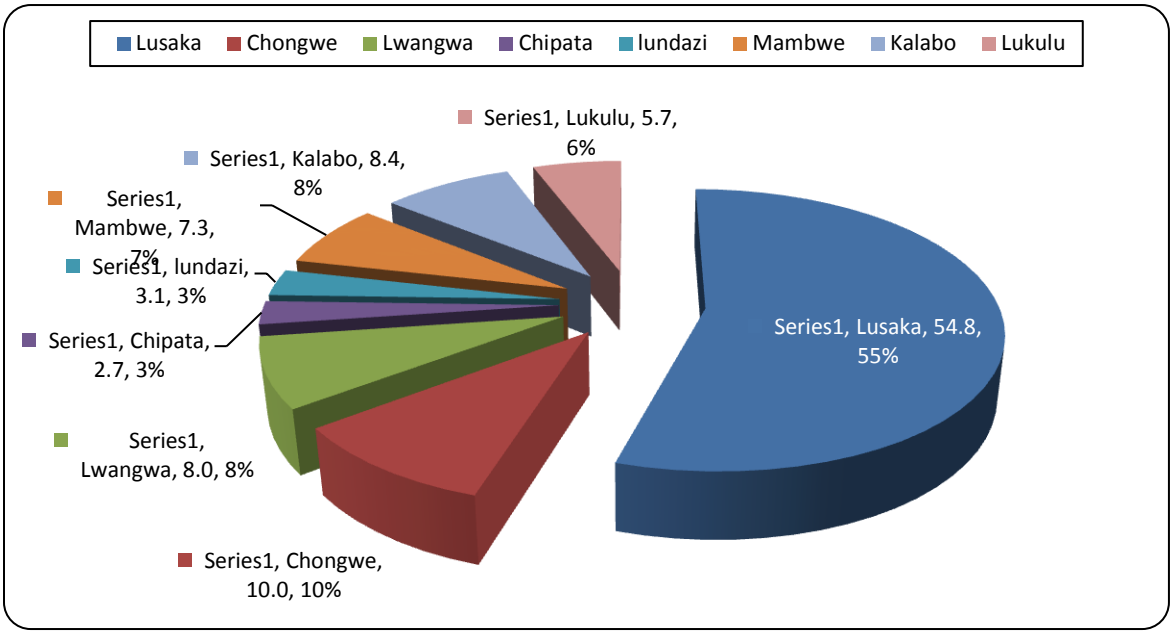
Figure 2: Percent of Print Materials Found in the Study Provinces (N=261)



ii) Coverage by District

Consistent with the province level availability of materials, more than half (55 percent) of the print materials were found in Luangwa, the urban district of Lusaka province, while 10 percent were found in Chongwe, a peri-urban district of Lusaka. The rest of the rural districts had 8 percent or less, with the exception of Mongu, the provincial district of Western Province, where no print materials were found (Figure 3).

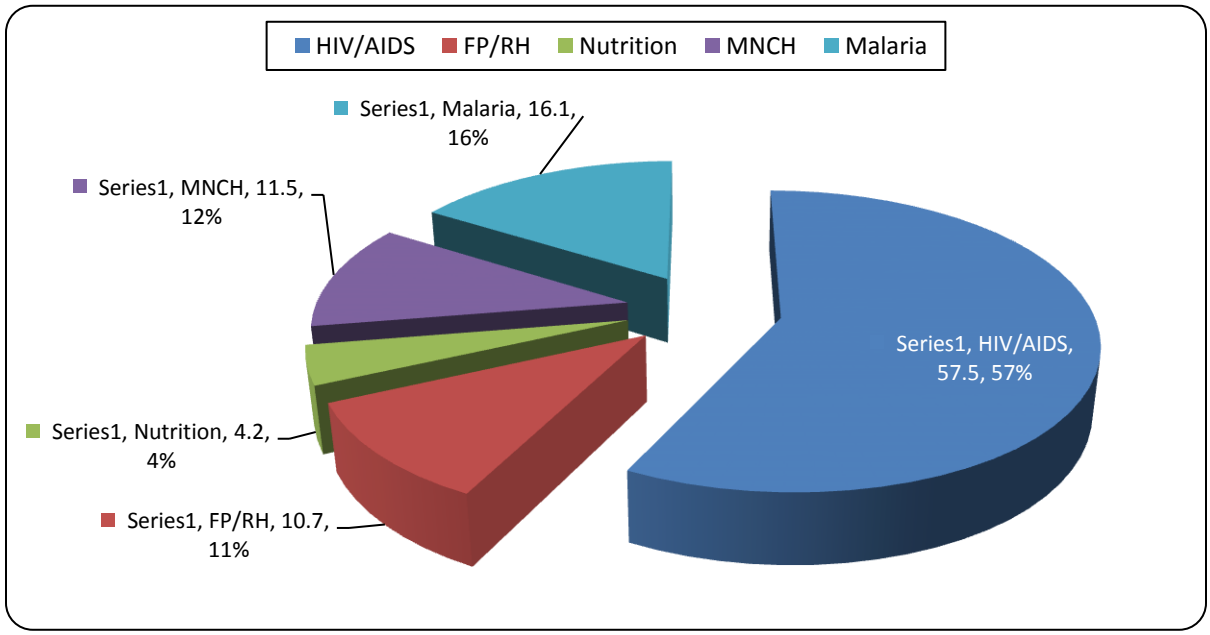
Figure 3: Percent of Print Materials Found in the Study Districts (N=261)



iii) Coverage by Topic

The print BCC materials found by the study team addressed all five targeted health topics (HIV/AIDS, FP/RH, nutrition, MNCH and malaria). However, the majority were on HIV/AIDS (57.5 percent), as shown in Figure 4. In contrast, very few were on nutrition (4.2 percent), FP/RH (10.7 percent), MNCH (11.5 percent) and malaria (16 percent), despite these being critical health concerns in the study areas. In addition, all the print materials addressed only a single targeted topic rather than integrating multiple health topics into a publication.

Figure 4: Proportion Distribution of Print Materials by Topic (N=261)



Responses from FGD and IDI participants reinforced this finding. The participants reported that BCC materials address key public health concerns in the community, but that most of the materials are on HIV/AIDs. At the time of the study, malaria was perceived to be the major health concern at HC and community levels. A female BCC focal point person in Chongwe emphasised that, *"70 percent of cases we see here are malaria related".* The community also expressed interest in BCC materials on non-communicable diseases, such as heart disease and cancer. A male community member from Chongwe said, *"Knowledge of diseases like cancer, blood pressure and diabetes will prevent us from witch-hunting when a family member suddenly drops dead".*

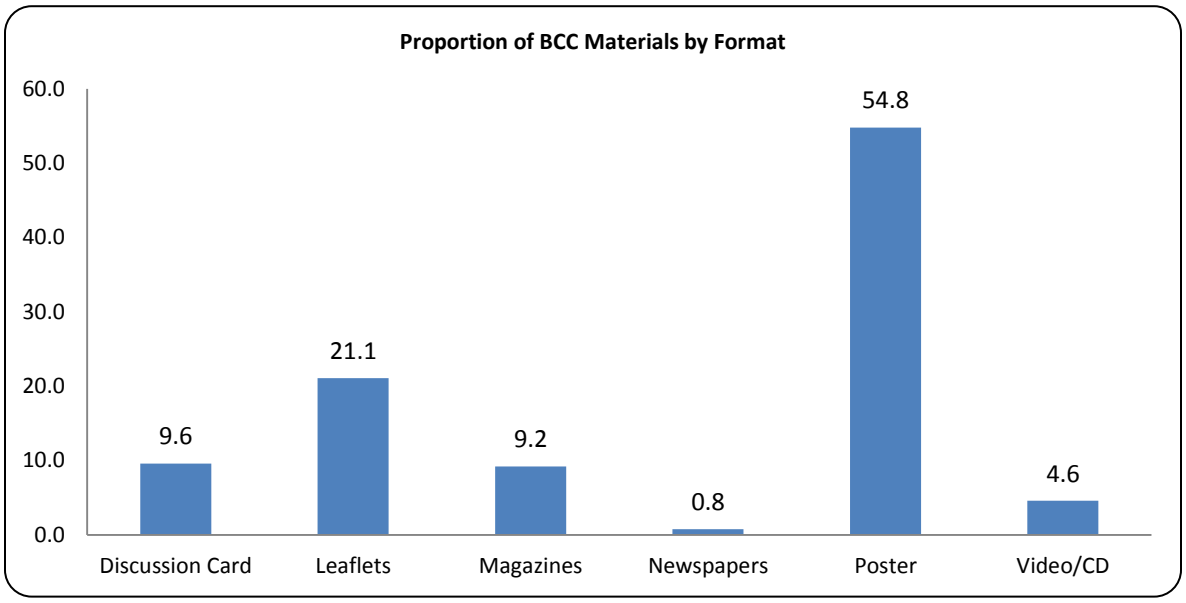
3.2.1.2 Attributes of Print Materials

This section presents a description of the various attributes of available print materials such as format, intended audiences, language used, and relevance to audience, adequacy of credit information and location of materials. Each of these attributes is described in detail below.

Format

More than half (54.7 percent) of the print materials identified in the study were posters (Figure 5). Other formats found included leaflets (21.1 percent), discussion cards[1] (9.6 percent), magazines (9.2 percent) and newspaper inserts (0.8 percent). In general, novelty items such as T-shirts, mugs, badges, ribbons and pens were not available at the community level. Although not readily available, a male community member from Lundazi explains the effectiveness of T-shirts, *"The T-shirts are useful to me and the community because, let's take for example a lady is wearing a T-shirt with HIV/AIDS prevention message or abstinence message, people will have an interest of what the T-shirt is portraying because she will be advertising around the community hence more people will get the message".*

Figure 5: Proportion of BCC Materials by Format



ii) Intended Audience

Approximately 71 percent of the print materials found by the data collectors targeted women and teenagers. Fewer than a third focused on men and there were no specific print materials primarily targeting children.

iii) Language Used

Most (96.6 percent) of the 261 print materials collected were produced in English, which some community members cannot read. A community member in Lukulu said, *"Production of print materials in English is a problem for some of us who did not go far in education".*

[1] Discussion cards are used for teaching and discussion purposes.

iv) Relevance to Audience

In general, FGD participants (both NHCs and community members) reported that print materials are important because they address public health issues affecting their communities. However, they also said many print materials are not appropriate for their intended audiences. For instance, many rural residents explained that they can not identify with the affluent characters in some of the materials. A male DHMT staff person suggested that, *"Before production of materials, research should be done to show what is really on the ground and not as Lusaka is set up".*

v) Publication Information

In order to identify who is involved in the production and distribution of BCC materials, the data collectors attempted to record the names of the writers/publishers, the year of production, the distributors of the materials and the partners who supported the production of the materials. However, most materials did not have attribution information. Only seven of the 261 BCC materials identified had appropriate attribution. Most of these materials were on HIV and were produced and distributed by SAFAIDS. Lack of a production date made it impossible to determine how long the materials have been in existence.

vi) Common Distribution Points

The 261 BCC materials were found at different locations. At the central level, these included the Afya Mzuri Resource Centre, MOH offices and the Society for Family Health (SFH). The Health Communications Programme's BCC Materials Catalogue (2009) contains information on print materials. At the district and HC level, materials – as noted above, mostly posters – appear on the walls of health facilities. A few materials, such as brochures, leaflets, booklets, and magazines, were found in health facility store rooms and in desk drawers.

3.2.1.3 Availability

In general, print BCC materials are not available at the community level; the study team found this to be true in all six study districts. All key informants, NHCs members and community members in the rural areas indicated that there were few or no BCC materials in their communities. A female NHC member from Chongwe said, "*The only problem is that they are few materials here in Chainda, I am sure you went around the community and you have seen for yourselves that there are only posters for politicians".* A male NHC member from Kalabo also said, *"The challenge is that they print materials in small quantities; they do not reach or cover all the villages in the community".* FGD participants reported that they do see print materials when they visit health facilities for various purposes such as antenatal care, FP, and immunisation.

3.2.2 Drama

The study found that health workers commonly use drama as a means to attract community members to health talks. A male NHC member from Kalabo explained*, "Drama groups are good because they attract different types of people … Most of the time that's how the clinic workers attract community members to attend health talks, because after drama group performances, that's when the health workers start educating the audience on various health topics like family planning, MNCH, malaria and other health problems".*

Community members reported that drama is the preferred communication channel, for the following reasons:

- Drama reaches more community members than other sources of information.
- Many people are interested in seeing a drama performance, so turnout is generally high.
- Messages are clear, especially when local languages are used.

- Drama attracts different types of audiences such as youth, women and men of all age groups
- Drama is entertaining.

While popular, drama also has limitations. Respondents said that drama usually is performed in central places, such as markets and clinics; it seldom is performed in hard-to-reach areas, limiting coverage. Respondents also identified lack of institutionalisation of drama groups as a limitation. Groups do not perform regularly; limited transport and technical and logistical support means they are mostly used for special events that may take place only once a year. Further, drama group scripts are not documented, making it difficult to do follow-up and evaluation.

3.2.3 Electronic Media

3.2.3.1 Radio

Radio was the second preferred source of information by community participants and various community radio stations were reported to broadcast in the study sites. Community members reported that they had learned a lot from the experts on the radio, and that by broadcasting health messages to communities, radio programmes add great value. In Chongwe, study participants complemented Sister Evelyn radio programmes. Other radio stations mentioned included Radio Breeze in Chipata, Maria and Feel Free in Mambwe and Lundazi, Radio Lyambai in Kalabo and Radio Liseli in Lukulu.

- Participants reported positive attributes about radio messages. These include:
- The messages reach everyone in the community.
- Radio covers a large population at one time.
- The messages reach all age groups, regardless of literacy.
- Information is spread faster through radio. It is a more reliable source because it sometimes gives the listener an opportunity to ask questions or solicit feedback, and to get first-hand information from the presenter.

A female community member from Mambwe further explained the benefits, stating, "*The good part with the radio is that they are able to describe everything, how a disease is spread and how you can get it".* A female community member from Lukulu also explained, "*The good thing with radio communication, the message reaches people very fast. Health workers do not need to travel. For example, travel from maybe Mongu to Lukulu just to come and inform us on the health problems, such as malaria or HIV/AIDS; they can just announce through the radio and people can get the message very fast".*

Despite the benefits, participants also identified challenges in using radio to communicate health messages to rural populations. The most commonly cited challenge was that a lack of radio signals, electricity, and batteries prevents most communities from using this messaging source.

3.2.3.2 Public Address System

The study also revealed that some communities in rural areas preferred a public address system, a mobile electronic device used to address people in their communities. This is the preferred communication channel of the Zambia News Information Services (ZANIS) over radio given poor radio signals and difficulties in accessing batteries. A male community member from Luangwa explained, "*The other convenient source is the ZANIS PA [public address] system, everyone has a chance to hear because the coverage is wide and they use the local language".*

3.2.3.3 Digital Video and Audio Recordings

Approximately 4.6 percent of BCC materials identified in the study were videos or CDs[2], as shown in Figure 5 above. Although some DVDs were found, mainly in Lusaka at the Afya-Muzuri Resource Centre, this was the least reported channel of communication. Key informants reported that generally they do not use video and audio recordings due to challenges lack of power, both electric and battery.

3.2.4 Interpersonal Communication

Dissemination of health messages through interpersonal communication – home visits, social gatherings and the like – though not well developed in the study sites, is also preferred by the community. Often these approaches correspond or reinforce messages delivered through print BCC materials.

3.2.4.1 Door-to-Door Visits

Community member participants reported door-to-door visits by community health workers and other community volunteers to be another preferred mode of disseminating health messages in rural communities. Participants considered this approach to be important because it can simultaneously provide individuals and groups with both health information and the opportunity to immediately ask questions and receive feedback. A community member from Lukulu said, "*The advantage of the door-to-door educators, they use the language we speak. They can reach many people, even the chronically ill in their homes".*

3.2.4.2 Social Gatherings

Social events – football matches, youth games, church meetings and drinking places, especially for men – are considered good venues for disseminating health messages to the community. A community member in Lundazi said, "*The health centre should take advantage of opportunities like football matches to give health education to the communities – more especially to men, who rarely visit clinics".*

3.2.4.3 Clinics and Schools

Community members explained that schools and clinics are a venue for disseminating and reinforcing health messages. They reported that their children are taught health messages by teachers. Students also are given print BCC materials, such as magazines and brochures, to read and to share with family and friends. If schools think that the students can not read the materials, they advise them to seek help from their guardians or friends. A female community member from Lundazi said, "*Me, I have learnt a lot from my children who talk about these health issues we are discussing … they bring small papers which talk about malaria and AIDS".* Health workers were also reported to offer health education at HCs and help those who had difficulties in reading the print materials available at HCs.

3.2.4.4 Community Mobilisation, Sensitisation and Group Discussions

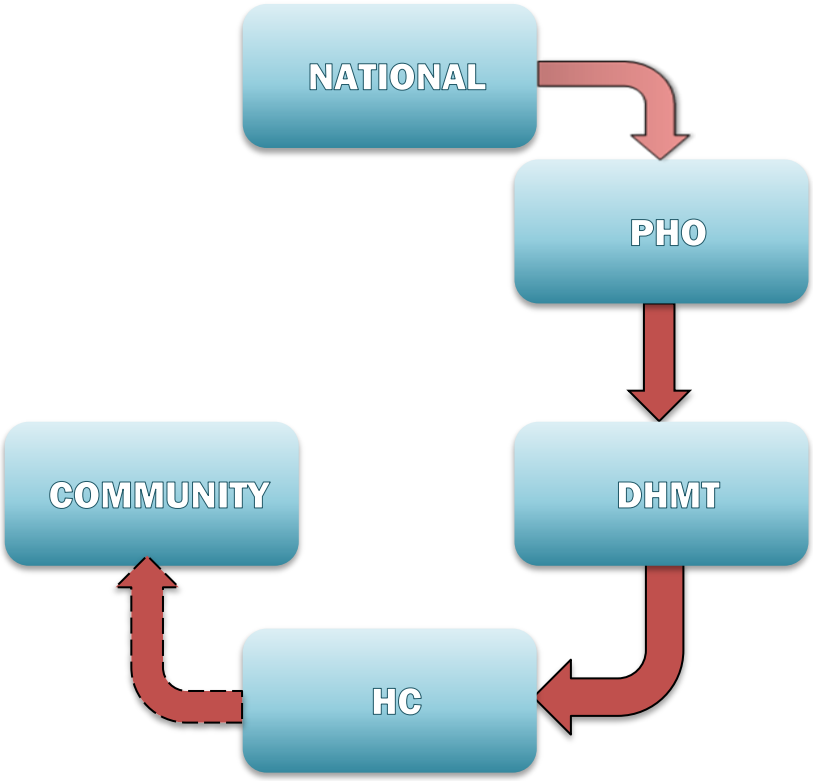
Community mobilisation and group discussions, though not well articulated by the community, were also mentioned as channels of communication for health messaging. Community members suggested that the HC staff should find ways to mobilise communities to spread key health messages. NHC members also believe that community mobilisation is a key communication channel. Once print BCC materials were collected from the HCs, NHCs with help from the headmen were able to mobilise the community, hence health messages reached everyone. BCC focal point persons said that, due to high levels of illiteracy and long distances to the health facilities, community mobilisation is preferable to print materials for spreading health messages.

[2] Videos and CDs were generally considered the property of facilities, such as a resource centre.

3.3 Distribution, Replenishment and Storage Systems for Print Materials

The distribution of print BCC materials varies across the different levels of the Zambian health system. A key informant from Lukulu describes the typical distribution process, *"From the national level, materials are sent to the province, a health education officer then distributes to the district, then health centres where they are either given directly to the community or through the NHC".* Figure 6 depicts this distribution chain. The link between the HC and the community is demonstrated with a broken line to indicate that there is no regular link between these two levels, which partially explains why materials are not available at the community level. Also, the distribution chain is unidirectional; there is no effective mechanism for the community to give feedback on print BCC materials to higher levels. This gap was noted by an NHC member in Chongwe: "W*e usually do not know what we expect, materials are just brought to us as there is no system for us to order the BCC materials we need".* Similarly, a Lubosi male NHC member said, *"I do not know how these guys [provincial and district level staff] do their ordering and requesting because we always receive very little [BCC] stuff. This is our major cry".*

Figure 6: Distribution Cycle for Print BCC Materials



Regular distribution link and irregular distribution link

3.3.1 Distribution at the District Level

All DHOs studied reported receiving some print materials from the PHO. Data collectors confirmed this after seeing BCC materials displayed health facility walls. However, there is no systematic mechanism used to distribute BCC materials to and from the district. The findings at district level are similar to those from provincial level. A key informant from Mambwe said, *"We go to the province and check if they have materials for us, if they are there we collect them and distribute to the clinics, we target places or clinics with a high incidence rate of a particular disease outbreak".*

Challenges were also reported at the district level. These included: a) shortage of staff to oversee health promotion activities, b) lack of transport to carry out health promotion activities such as distribution of print materials, c) inadequate funding for health promotion activities, and d) non-availability of effective communication channels. A focal point person from Chongwe addressed one challenge by explaining, *"Here we do not have enough health education focal point persons who are employed specifically for health promotion activities and coordination".*

3.3.2 Distribution at the Community Level

Responsibility for movement of print BCC materials from district to HC and community levels is not well defined. One key informant at Chipata Provincial Health Office explained, *"We write to the district that we have BCC materials and then they come to collect, but from there I am not sure how they are distributed to the community".* Although HCs and NHCs are considered the main conduit through which BCC materials are distributed at the community level, there is no coordinated and effective system for doing so.

In general, the NHCs confirmed that the supply of print materials was inadequate and irregular and that there is no distribution system. Further, NHCs reported that they receive print materials during their training (for those trained) and during special events, such as national days for HIV/AIDs, malaria and TB as well as child health week. They also explained that sometimes they collect print materials from DHMTs and HCs, when materials are available.

Obstacles to proper distribution also exist at the HC level. Since most HCs do not have vehicles, transportation is a major challenge. The HCs must wait for the print materials to arrive from the DHO. In most cases, the DHO does not know the quantity and type of materials the HC needs and, therefore, the demand for the materials is not met. In general, the replenishing of materials was reported to be erratic and inconsistent; sometimes materials intended for a special event arrive after the event has taken place.

3.4 Stakeholders Involved in BCC Materials and their Roles

Thirty stakeholders/partners involved in various aspects of BCC materials such as production, distribution, funding, training and education were reported to be operating in the study sites. Key informants and the NHC members reported that almost a quarter of the stakeholders mentioned were found in the six districts. Participants also reported that international NGOs were more active than the local NGOs in the production and distribution of BCC materials.

The MOH, Centre for Infectious Disease Research in Zambia (CIDRZ), ZISSP and SFH were the most commonly mentioned partners. The MOH and ZISSP were reported to be involved in all the five health areas that this study covered. CIDRZ focuses on HIV/AIDS, MNCH and nutrition, SFH on malaria and FP/RH.

3.5 Effectiveness of NHCs in Use of BCC Materials

To assess NHC effectiveness in using BCC materials, the NHC members were asked if they had access to BCC materials and whether they knew how to use the materials to encourage community members to access health services and practise positive health seeking behaviours.

3.5.1 Ability of the NHCs to Use BCC materials

Although NHCs existed in all six study districts, some communities did not have an NHC or the NHC was not active. NHCs in Chongwe were generally more active than those in other districts: members frequently attend stakeholder workshops and also help provide basic health education to the community. BCC focal points persons and community members said that NHCs are an important community health structure where they exist; they play an important role in sensitising the community on healthy behaviours using BCC materials, distributing BCC materials to the community and assisting HCs in weighing children during under-five activities. NHCs were reported to work closely with the HCs. Some HC staff also explained that they involve the NHCs in planning processes so that the NHCs are aware of progress in their district. They also said that NHCs help clean HC surroundings and dispense drugs to patients.

Out of the 19 health officers interviewed, 16 (84.2 percent) stated that NHCs effectively use BCC materials. When asked why, the majority of the key informants at the DHMT said that they train the NHCs and have quarterly meetings to assess their progress. Health officers also reported that the NHCs help to explain health messages in local languages.

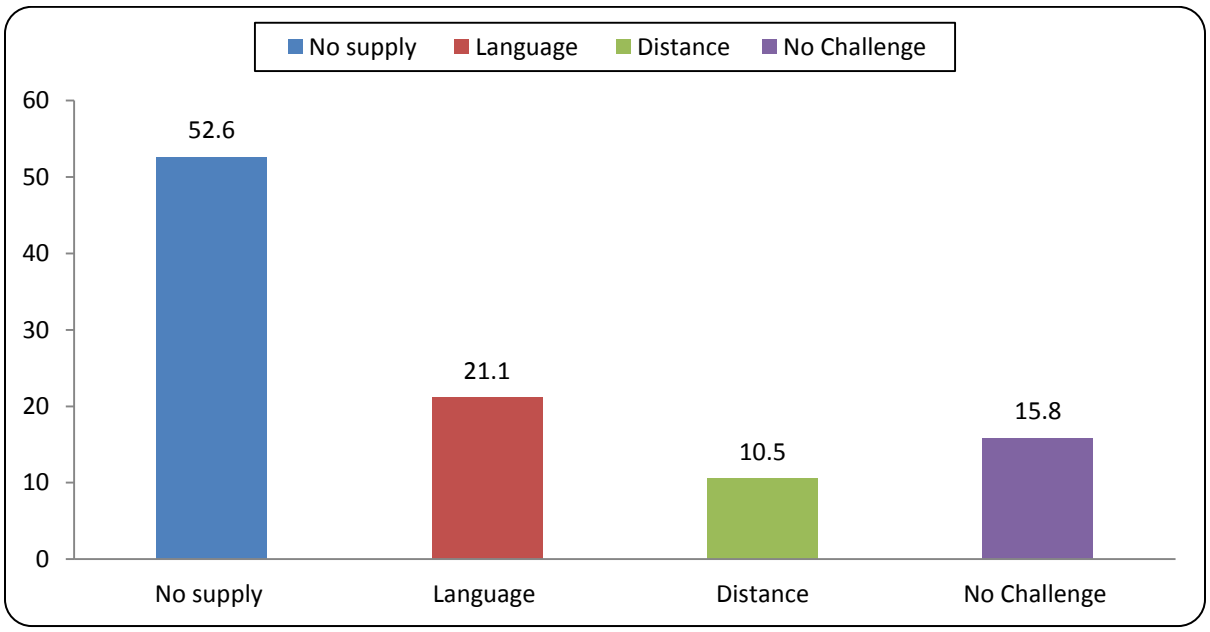
This was not the universal view, however. The health officers from Lundazi, Kalabo and Lukulu reported that the NHCs were not able to use BCC materials effectively. When asked why, two from Lukulu and Lundazi cited that most of the NHC members have limited education, so they find it difficult to translate the information from English into local language. The BCC focal point person in Lukulu said, "*Mostly it's because education [levels] of NHCs are low and they cannot fully understand the message because most materials are in English".* The health officer from Kalabo felt that lack of training was the major factor. Most of the NHC members reported that irregular training contributed significantly to their ineffective use the BCC materials.

Most of the community members reported that NHCs were effective in sensitizing their communities to positive health seeking behaviours. Many explained that people in the community were getting a lot of information from NHCs, such as the importance of VCT, antiretroviral treatment and other health services. A female community member from Chongwe said, *"I think we are just thanking these people for the good job they are doing because they have helped us in so many different ways and because of them there has been a reduction in cases of complicated diseases in this our community. They have also helped in the area of making people go for VCT, because many people here, especially men, never used to accept going for it, but now they are all going without problems".* In general, trained NHCs members reported that health messages in BCC materials are easy to understand and that they know how to use the materials to educate the community members.

3.5.2 Challenges Faced by NHCs

The major challenge faced by NHCs was the lack of BCC materials at the community level. Slightly over half (52.6 percent) of BCC focal point persons reported inadequate supplies as a major challenge followed by language barrier (21.1 percent), as shown in Figure 7. Other challenges include long distances to the collection point and lack of public transport. Some also cited poor motivation due to lack of incentives, inadequate training, high illiteracy levels and poor participation of community members in meetings and other planned activities.

Figure 7: Challenges NHCs Face in Accessing BCC Materials, Reported by Focal Point Persons (N=19)



3.6 Summary of Strengths and Challenges of BCC Materials

The findings reveal strengths and challenges in the development, implementation and utilisation of available BCC materials. Key strengths and challenges are pointed out here.

3.6.1 Strengths

The availability of community health structures, such as NHCs and other community agents (i.e. community health workers, traditional birth attendants and malaria agents), provides leverage for disseminating BCC materials at the community level.

The use of HCs for BCC activities facilitates health system and community engagement. In most communities, HCs are a conduit for distributing and promoting use of BCC materials.

Involvement of many stakeholders in BCC material development and implementation, if effectively coordinated, can have a synergistic effect for mobilising and promoting the use of BCC materials at community level.

BCC focal point persons reported that sensitisations in the community through community mobilisation, drama and radio/TV adverts increased the number of community members accessing health services[3].

[3] This has not been documented through evaluation of the BCC materials and their impact on the community.

3.6.2 Challenges

- Lack of print BCC materials at the community level limits utilisation of materials. In general community members access BCC materials from: a) HCs and b) at special community events. However, this sourcing is not consistent.
- Language and high illiteracy levels frequently limit the proper use of BCC materials by community members and NHCs. This challenge was clearly explained by a male community member from Luangwa: "Not all of us know how to read, it is not possible every time you see a poster you have to find someone to read it for you". A female community member from Kalabo said, "The disadvantages of BCC materials are that most of them are printed in English and you know in rural areas like here most of the people are illiterate and cannot read". District level key informants reported that community members sometimes remove BCC print materials posted on trees or walls because they feel the materials serve no purpose since they do not understand the language. A female MCH coordinator from Lukulu rural district said, "They do not know how to read English and, as a result, they remove materials when we put them in the community [and use them] to decorate their homes or for wrapping food".
- Long distances to health facilities and lack of public transport hinder accessibility to and utilisation of BCC materials by both the NHC and community members. A community member in Chongwe said, "Long distances to reach to health places where the BCC materials are found is the major challenge in this community".
- Lack of community participation limits utilisation of BCC materials. The community is generally not involved in the process of developing BCC materials, which results in poor understanding and lack of ownership of the materials by the community. Moreover, participants reported poor community attendance at BCC activities organised by HCs and NHCs. A male NHC member from Chongwe said, "The problem that we have here is that sometimes community members do not come when we call for meetings; in other words the community does not support the work of NHCs".
- Lack of adequate financial support in the production and distribution of BCC materials also contributes to the unavailability of BCC materials at all levels. The BCC focal point persons at district and provincial levels reported that they lack financial capacity to produce and distribute the BCC materials to the community. Therefore, there is a heavy reliance on support from stakeholders. NHCs, the link between the HC and the community, also feel that lack of financial support prevents them from executing their duties as per their guidelines. Due to long distances from the health facilities, the majority of the NHCs suggested that the MOH and its stakeholders provide bicycles to enable distribution of BCC materials to the community.

4. Discussion

BCC materials play an important role in initiating and maintaining healthy and positive individual and community behaviours (Cacioppo et al. 1991). A lack of appropriately targeted BCC materials at the community level is a barrier to effective health promotion, particularly in rural areas where resources are limited and the need for health information is great. By taking stock of existing BCC materials and their use in the six study districts, this study revealed shortcomings – in the availability and content of BCC materials and approaches – that hinder health promotion efforts.

4.1 Type and Availability of BCC Materials

Several factors currently impede the use of the BCC materials found in the six study districts. Supply is a major constraint. Despite efforts by the government and its partners to provide an adequate number of a variety of materials, there is a supply problem at all administrative levels – provincial, district and community. Rather than being distributed throughout the community, most materials remain in HCs, and community members have access to them materials – and the health information they contain – only when they visit a facility.

The study identified various BCC material formats/approaches. The majority were print materials, mostly posters. The lack of variety is significant, since studies have shown that low literacy levels in many communities limits the use of print materials and therefore the widespread comprehension of health information (Underwood et.al 2007). Moreover, as behavioural theory demonstrates, it is important to use multiple communication channels – printed materials, drama performances, radio broadcasts and so forth – to effectively deliver a health message and achieve the desired change in knowledge and behaviour (Rogers et.al 1993).

Finally, most existing BCC materials focus on HIV/AIDS. Very few address other health topics, such as nutrition and malaria, even though malaria is considered a major problem at the HC and community levels.

4.2 Target Audience

Current BCC materials are mostly targeted to women, because women and children are the most vulnerable groups. However, this focus excludes other audiences, such as men. Since men tend to be the main decision makers on household issues, including health, they greatly influence the health care of women and children. Therefore, the failure of BCC materials to target men, both regarding their own health issues and issues traditionally associated with women and children, could undermine the utilisation of BCC materials and desired behaviour change.

The study also found that the majority of existing BCC materials depict urban situations and/or characters. As a result, rural audiences do not identify with them or benefit from their messages. This perceived irrelevance to rural residents may also be why some community members remove BCC materials from public places.

4.3 Preferred Channels of Communication

In the six study sites, drama is the preferred way to communicate health messages and provide services, particularly to populations in hard-to-reach rural districts. However, performances are often limited to infrequently occurring national and community events.

Radio is another preferred, albeit less widely accessible, channel of communication. It theoretically has wide coverage and it is thought that its expert commentators are effective. However, lack of strong

transmitting power and of electricity and batteries limit its use in rural communities and especially in hard-to-reach areas.

Community members also expressed a preference for dissemination of health messages through interpersonal communication, though this medium is not well developed in the study districts. These approaches should be invested in for use especially in areas unreachable by radio signals or drama groups.

4.4 Language Used in BCC Materials

Most of the materials identified were in English, the lingua franca and official language of Zambia. However, in rural areas, where English is not the primary language, English-language BCC materials are of little use. While rural populations might have difficulty reading regardless of which language is used, participants clearly voiced the need for materials in local language. Related to this, literacy levels should be considered in the development of BCC materials. More pictures and relevant characters should be used so that people with low literacy can understand the message without having to read.

4.5 Distribution System for BCC Materials

The current distribution system for BCC materials from the HC to the community level, which depends on NHC members retrieving the materials from the HCs and distributing them in communities, is not effective. While NHCs are generally an important link between the HC and the community, some HC catchment areas do not have NHCs, or the NHC is inactive. Lack of transport also limits NHCs' ability to distribute materials. Moreover, the lack of a feedback mechanism for communities and HCs to express their need for BCC materials hinders access, and further weakens health promotion efforts.

4.6 Stakeholder and Community Involvement

This study identified 30 partners that are involved in the production and distribution of BCC materials. International NGOs are more active in the production of the materials than are local NGOs. This dependence on international NGOs may jeopardize the sustainability of BCC programs. Therefore, there is a need to build capacity of local NGOs in the development, production and distribution of BCC materials. Further, the fact that very few BCC stakeholders work in hard-to-reach areas suggests that the geographical distribution of partner activities is not well coordinated.

Community involvement in BCC could be strengthened. Lack of involvement of community members in developing BCC materials and their poor attendance at BCC activities organised by HCs and NHCs are some of the factors that limit utilisation of BCC materials by the community.

4.7 Incorrect Use of BCC Materials

Incorrect use of print BCC materials was reportedly common at the community level. Community members often remove BCC materials from designated places and use them for other purposes such as food wrappings, table mats, house decorations and book covers. This suggests that the community does not fully understand and appreciate the relevance of BCC materials.

4.8 Financial Costs of Producing and Distributing BCC Materials

Inadequate financial capacity to produce and distribute the number of BCC materials needed to meet community needs was also reported as a major challenge. Current production relies on short-term donor-supported projects. Most DHMT focal point persons reported that they lack the funds to support NHCs in their distribution of BCC materials.

5. Recommendations

This section presents recommendations arising from the study findings and discussion.

5.1 Availability of BCC Materials

- The government, in collaboration with its partners, should develop a plan to review the current production and distribution of BCC materials with the objective of developing a comprehensive BCC strategy to ensure adequate and consistent availability of BCC materials at all levels, including the community.
- BCC materials on other health areas, such as FP/RH, nutrition, malaria and non-communicable diseases, as well as epidemic-prone diseases such as cholera, should be developed and disseminated.

5.2 Design and Implementation of BCC Materials

Overall proper monitoring of the design, development, implementation and evaluation of the effectiveness of all BCC materials and activities is needed. Specific recommendations are listed below.

5.2.1 Target Audience

- Print materials should be improved by using characters with which the intended audience can identify.
- To complement current BCC materials, which focus primarily on women and youth, BCC materials should be designed that consider all relevant target audiences, including men and other influential groups.
- To ensure that all target audiences are most effectively reached, the materials development process should include a comprehensive audience segmentation and analysis.
- The development process also should include adequate pretesting for effective message delivery to all intended audiences.

5.2.2 Language Used in BCC Materials

- New BCC materials should be produced in local languages and low literacy formats to more effectively reach more audiences.

5.2.3 Communication Channels

- There is a need to explore ways to increase the use of communication channels that extend beyond posters, particularly for rural communities. This could include:
    - Strengthening the capacity of drama groups and institutionalizing the approach, thereby supporting the groups to improve community level outreach and encourage community level ownership of BCC programmes and commitment to behavioural change.
    - Facilitating and institutionalizing the strengthening and expansion of interpersonal communication interventions and interactive community programmes like community, school and church meetings.
    - Exploring the use of social media and cell phones for health communication.

5.3 Distribution Mechanism

- The government, with the support from partners, should develop a system for ensuring equitable geographical and population-based distribution of BCC materials in all districts, including a feedback loop.
- To address the issue of transportation for NHCs to help distribute materials, other intermediate means of transport such as bicycles should be provided to NHCs.
- To help reduce the misuse of BCC materials within the community, the government and its partners should develop and implement interventions to educate the community about the proper use and value of BCC materials.

5.4 Stakeholders Involvement

- The government and its partners should strengthen the coordination and monitoring of BCC activities at all levels.
- To help ensure sustainability of BCC efforts, local NGO capacity to develop and implement BCC activities should be strengthened.
- Effective systems for actively engaging the community in the design and distribution of BCC materials should be instituted.
- The government should put in place a mechanism indicating which rural districts need partner support for BCC efforts and what type of support is required.
- The government and other stakeholders should consider training and deploying BCC specialists in all the districts to improve BCC programming at the district and community levels.

5.7 Strengthening NHC Involvement

- NHCs should be provided with BCC materials for distribution to their communities.
- NHCs should be trained to effectively use BCC materials.

6. Bibliography

Afya-Mzuri. 2005., Where to Find Information on HIV and AIDS (2nd edition).

Carol Underwood, Elizabeth Serlemitos and Mubiana Macwan'gi. 2006. Health Communication in Multilingual Context: Reading Preferences and Practices among Literate Adults in Zambia. (In Press, expected June 2007). Health Communications Journal.

Cacioppo T. John and Petty E. Richard. 1981. Attitudes and Persuasion: Classic and Contemporary Approaches. Dubuque, Iowa: Wm. C. Brown Company Publishers.

Health Communication Partnership Zambia. September 2009. HCP Materials Catalogue.

Macwan'gi M., Chishimba M., Munyima M., Phiri B. and Gboun G. 2011. Assessment of Behaviour Change Communication (BCC) approaches, Messages and materials. Chemonics, Communications Support for Health Project.

Ministry of Health. 2009. 2009 Action Plan. Lusaka: Government Republic of Zambia.

Morse JM: Determining Sample Size. Qualitative Health Research 2000, 10:3-5

Ministry of Health. 2011-2015 NHS Plan.

Ministry of Health. 2009. Guidelines for Health Promotion Programmes Implementation at District Level.

Ministry of Health. 2009-2014 Maternal, Newborn and Child Health Communication Strategy.

Ministry of Health. 2009. Guidelines for Developing Health Programme at Community Level.

Ministry of Health. 2009. National Health Promotion Guidelines for Implementation of Activities at District Level.

Ministry of Health. 2006. National Health Strategic Plan 2006, Lusaka: Ministry of Health.

Ministry of Health. August 2006. National Food and Nutrition Policy Implementation Plan.

Ministry of Health. 2011-2014 National Malaria Communication Strategy.

Rogers M. E. 1983.Diffusion of Innovation. Third Edition. The Free Press.

Ross, Susan Rae. 1998. Promoting quality maternal and newborn care: A reference manual for program managers. Atlanta: CARE.

Appendix 1: Summary of IDIs and FGDs Conducted

Province/District	Focus Group Discussion					In Depth Interviews
	Type	Number of FGDs	Number of Participants	Female	Male	Number
Lusaka Province						
Lusaka	n/a	n/a	n/a			10
Chongwe	NHC members	4	35	15	20	3
	Community members	4	38	19	19	
Luangwa	NHC members	3	18	8	10	3
	Community members	3	21	10	11	
Subtotal		**14**	**112**	**52**	**60**	**16**
Eastern Province						
Chipata	n/a	n/a	n/a			4
Lundazi	NHC members	4	34	18	16	3
	Community members	4	34	18	16	
Mambwe	NHC members	4	40	21	19	3
	Community members	4	37	20	17	
Subtotal		**16**	**145**	**77**	**68**	**10**
Western Province						
Mongu	n/a	n/a	n/a			4
Kalabo	NHC members	2	23	8	15	4
	Community members	4	33	14	19	
Lukulu	NHC members	2	18	7	11	4
	Community members	4	35	18	17	
Subtotal		**14**	**109**	**47**	**62**	**12**
Total Sample		**42**	**366**	**176**	**190**	**38**

n/a – FGDs were not collected at provincial level.

Appendix 2: DHMT Questionnaire

Zambia Integrated Systems Strengthening Programme (ZISSP)

Development of Behaviour Change Communication (BCC) Inventory

IN DEPTH INTERVIEW QUESTIONNAIRE

MOH DISTRICT MEDICAL OFFICE STAFF

Name of Institution: _____

Province: _____District _____

Date of Interview:_____(Day/Month/Year) _____

Position of Interviewee: _____

Years served in this position:_____ Sex: _____

Professional background: _____

Interviewer's Name: . _____

Start time: _____End time:_____

Results of Interviewee: **1.** Complete _____ **2.** Incomplete _____

(Reason) _____

Reviewers' Name: _____

Instructions to Interviewer:

Note that this questionnaire is for the District Medical Office Staff

Please ensure you ask all the questions and record all the responses

Observe the skip pattern

Observe ethical considerations and ensure ethical form is signed before interviews

Were required, please circle your response number

Introduction

Greet the respondent with respect and introduce yourself.

My name is ……..I am from the University of Zambia – Institute of Economic and Social Research. I am conducting a study on the development of Inventory of Behavioural Change Communication (BCC) Materials on behalf of ZISSP (present letter). In this assignment, I am interviewing different categories of respondents with the aim of developing an inventory of existing materials at Provincial, District and Community level in Zambia. This will later be shared among stakeholders and be used to inform the development of a valid community BCC strategy.

Before we begin the interview please allow me to get your consent by reading out the instructions and your rights in this interview (read consent form). Do you have any questions? If you agree, kindly sign the form.

Thank you.

STRENGTHS, WEAKNESSES AND GAPS

Category Description	***Response (circle response were necessary)***
Planning and Development	
Do you have an action plan that includes BCC activities for your district? ***(If yes request to see a copy and go to Q3)Indicate whether copy is available***	Yes ***(Go to Q3)*** No I don't know
If no, why not?	
What are the main activities of the action plan?	
Are you involved in the production of BCC materials?	Yes ***(Go to Q6)*** No I don't know
Why are you not involved? ***Go to Q8***	
How are you involved?	
How do you identify topics to be included/covered in the BCC materials?	

Category Description	*Response (circle response were necessary)*
Are there any topics you think are **NOT** covered in the BCC materials developed in the following programme areas?	
HIV/AIDS	
Family Planning and Reproductive Health (FP/RH)	
Malaria	
Maternal Newborn, Child Health (MNCH)	
Nutrition	
Which health programme areas are MOST covered and why?	.
Are there areas of health you think are **NOT** covered in the BCC materials developed?	Yes No ***(Go to Q12)*** I don't know
If yes which areas could these be?	
How do you select an audience to address your BCC materials to?	
HIV/AIDS	
Family Planning and Reproductive Health (FP/RH)	
Malaria	
Maternal Newborn, Child Health (MNCH)	
Nutrition	

Category Description	*Response (circle response were necessary)*
Do you provide epidemiological evidence to be used in the production of BCC materials?	Yes No ***(Go to Q15)*** I don't know
Please explain your answer	..
Monitoring and Evaluation	
Does your BCC programme have defined indicators?	Yes No ***(Go to Q17)*** I don't know
If yes please give examples	

AVAILABILITY, STORAGE, DISTRIBUTION MECHANISM AND UTILISATION

Category Description	*Response (circle response were necessary)*
Availability	
What type of BCC materials is readily available here at your office? ***(multiple response possible do not read out list)***	Video Audio Drama Poster Flip Charts Novelties Branded T-Shirts Others (Specify)
Do you always meet the demand for BCC materials?	Yes No I don't know
If you don't meet the demand, what could be the reason?	
Storage	
Do you have a central storage facility for BCC materials?	Yes No ***(Go to 24)*** I don't know
Is your storage facility adequate?	Yes No I don't know
If no to **Q22** why not?	
Distribution	

Category Description	*Response (circle response were necessary)*
Briefly describe the distribution mechanism of BCC materials from provincial level to districts and from districts to communities? ***(Probe for order list, request list)***	
What are the challenges in IEC/BCC programming at the district and community level? ***(Probe for appropriate channels, communication, dissemination, distribution)***	
District level	
Health centre level	
Community level	
What would you recommend as a solution to each of these challenges?	
Utilisation	
How do you describe the coverage of your BCC materials? ***(Probe geographical and population, hard to reach areas etc)***	
Are BCC materials utilised as intended? Please explain	
What are the challenges in BCC materials utilisation?	.
How do you ensure proper utilisation of BCC materials? ***(Probe: training and feedback)***	

ABILITY OF NHCs TO ACCESS AND USE BCC MATERIALS

Category	***Response***
What is your role in ensuring that NHCs have easy access BCC materials?	
What challenges do NHCs face in accessing BCC materials?	

EFFECTIVENESS OF NHCs TO USE AVAILABLE BCC MATERIALS

Category	***Response***
Do you think NHCs have the ability to use BCC materials effectively?	Yes No I don't know
Please explain your answer	
In which ways do you think BCC materials help NHCs service delivery? ***(Probe for community mobilisation)***	

GENDER

Category	***Response***
Are there specific needs for men and women for BCC materials?	Yes No ***(Go to 42)*** I don't know

Category	***Response***
What are the specific needs?	
Needs for women	.
Needs for men	
Please explain your answer	
How appropriate are the current channels of communication being used especially for men and women?	
What are the gender barriers in terms of access to information?	
How can these barriers be addressed?	

PRODUCERS OF BCC MATERIALS, DRAMA AND COMMUNITY RADIO

Who are the major stakeholders/ partners in the implementation of BCC programmes areas mentioned below and what are their roles, strengths and challenges?				
Programme Area	**Partner**	**Role**	**Strength**	**Challenge**
HIV/AIDS				
FP/RH				
Malaria				
MNCH				
Nutrition				

Thank you

Appendix 3: Focus Group Discussions Guide for Neighbourhood Health Committees

Zambia Integrated Systems Strengthening Programme (ZISSP)

Development of Behaviour Change Communication (BCC) Inventory

FOCUS GROUP DISCUSSIONS GUIDE FOR NEIGHBOURHOOD HEALTH COMMITTIES

Instructions to Facilitators:

Ensure that you have a group of about 8- 12 participants and is gender representative as much as possible

Greet everyone with respect and introduce yourselves and explain the objective of your visit and also allow participants to introduce themselves

Ensure that you have one research team member to take notes

Read out/explain the informed consent and ensure everyone signs

Take down particulars of participants (gender, position held & name of NHC)

Give tugs to respondents for discussion purposes

Position the recorder in a central position where everyone's voice can be recorded clearly

Introduction

Greet the respondent with respect and introduce yourself. We are from the University of Zambia – Institute of Economic and Social Research and are here to discuss health information materials with you. We want to know about what materials you receive and how these materials help you. We also want to know what additional information you need.

Before we begin the interview please allow us to get your consent by reading out the instructions and your rights in this interview (read consent form). Do you have any questions? If you agree, kindly sign the form.

Ice breaker question

- What are the common health problems in this community?

A. Availability, Distribution Mechanisms and Access to BCC Materials

1. What are your main sources of information or channels of communication for health information in this community?

   Probe:

   - *IEC/BCC Materials on each of the following areas: HIV/AIDS, FP/RH, MNCH, Malaria and Nutrition*
   - *From who i.e. teacher, parents, NHC members, friends and workmates etc*
   - *Programme sources like child health week, Safe Motherhood Week, World AIDS Day*
   - *Information on outbreaks such as measles, cholera etc*

2. In your work as NHCs members have you ever used BCC materials?

   Probe:

   - *Where did you get them from?*
   - *What materials were they (the 5)?*
   - *How do you use them? How do you replenish them?*
   - *Are they easy to use?*
   - *Is there a system of receiving feedback from the community? Explain*

3. How easy is it to get information from each of the sources you have mentioned? Explain your answer

4. Do you face any challenges in accessing BCC materials?

5. Are there differences between BCC materials for NHCs and for the general communities? Explain

6. What support do you need to use the available BCC materials effectively? Explain

7. Are you trained in using these BCC materials? If yes, what training was it? Who trained you? How long was the training?

8. What are your most preferred channels/sources of information in this community?

Probe: *HIV/AIDS, FP/RH, MNCH, Malaria and Nutrition*

9. Who is your primary target when disseminating information? And why?

10. Who is more likely to spread the information if targeted, and why?

11. Are there sources of information or channels of communication for health information that are best for men, women and youth men? Explain

B. Main Actors Producing BCC Materials, Drama and Community Radio

12. Who produces these BCC materials you identified?

    Probe: *contributors and their roles*

13. Are you involved in the production of BCC materials? If yes how?

14. Do you provide feedback in the production BCC materials? How?

15. Do you have community drama groups? If yes, what is the role of these drama groups in promoting health in the community?

    Probe:

    - *Names of drama groups*
    - *Main health programme areas*

16. Do drama groups have enough skills to develop their own scripts?

17. Do you have community radio programmes on health? If yes which ones?

    Probe:

    - *What health programmes do they feature?*
    - *Are the airing times suitable for the intended purposes*

18. How does the NHCs organise themselves and the community to listen to the mentioned programs?

19. What feedback mechanism is available to share knowledge and clarify issues or concerns?

C. Strengths, Weaknesses and Gaps (NHCs' Effectiveness & BCC Utilisation)

20. How do you use BCC materials and for what purpose?

    Probe:

    - *Community mobilisation*
    - *Positive health seeking behaviour*

21. Are these BCC materials relevant to the kind of work you do? How?

    Probe: *language, quantity, timeliness, audience, topics, message appropriateness*

D. Barriers to use of Available BCC Materials

22. Are all the materials that you receive utilised? Explain

23. What things make it difficult for you to use BCC materials?

Probe:

- *Training in BCC,*
- *Language,*
- *Quantity,*
- *Distance,*
- *Mode of communication,*
- *Culture & traditions,*
- *Appropriateness of messages,*
- *Messages not clear*

24. What measures should be put in place to overcome these gaps

End

Thank you!

Appendix 4: Focus Group Discussions Guide for Community Members

Zambia Integrated Systems Strengthening Programme (ZISSP)

Development of Behaviour Change Communication (BCC) Inventory

FOCUS GROUP DISCUSSIONS GUIDE FOR COMMUNITY MEMBERS

Instructions to Facilitators:

Ensure that you have a group of about 6-12 participants and is gender representative as much as possible

Greet everyone with respect and introduce yourselves and explain the objective of your visit and also allow participants to introduce themselves

Ensure that you have one research team member to take notes

Read out/explain the informed consent and ensure everyone signs

Take down particulars of participants (sex, name of community)

Give tugs to respondents for discussion purposes

Position the recorder in a central position where everyone's voice can be recorded clearly

Introduction

Greet the respondent with respect and introduce yourself. We are from the University of Zambia – Institute of Economic and Social Research and are here to discuss health information materials with you. We want to know about what materials you receive and how these materials help you. We also want to know what additional information you need.

Before we begin the interview please allow us to get your consent by reading out the instructions and your rights in this interview (read consent form). Do you have any questions? If you agree, kindly sign the form.

Ice breaker question

- What are the common health problems in this community?

E. Availability, Distribution Mechanisms, Producers, Access and Utilisation of BCC Materials

25. What are your main sources of information or channels of communication for health information in this community?

    Probe:

    - *IEC/BCC Materials on each of the following areas: HIV/AIDS, FP/RH, MNCH, Malaria and Nutrition*
    - *From who i.e. teacher, parents, NHC members, friends and workmates etc*
    - *Programme sources like child health week, Safe motherhood Week, World AIDS Day*
    - *Information on outbreaks such as measles, cholera etc*

26. For each source/channel of communication identified what are the advantages and disadvantages.

27. What are your most preferred channels/sources of information in this community?
    Probe: *HIV/AIDS, FP/RH, MNCH, Malaria and Nutrition*

28. Are there sources of information or channels of communication for health information that are best for men, women and youth men? Explain

29. What BCC Materials have you seen/heard in this community? What were they about

30. For each of the material you have identified, how useful are they to you or your community? Explain

31. Are these messages easy to understand? Explain

32. Are these messages appropriate to the people they are intended for? Explain

33. In your opinion, are there some health topics which you would like to get information on but are not covered? Which topics, please explain.

F. Barriers to use of Available BCC Materials

34. What challenges or difficulties do you face in accessing BCC materials?
    Probe: *For cultural and traditional challenges*

35. What measures should be put in place to overcome these hindrances?

G. Effectiveness of NHCs

36. Do you know what NHCs are supposed to do in your community? Explain

37. Are NHCs caring out their roles effectively? Explain

38. How do NHCs help you in your community?

    Probe*: For Information provision and community mobilisation*

End

Thank you

Appendix 5: BCC Documentation Guide

INSTRUCTIONS

FOR ENTERING INFORMATION ON BCC MATERIALS FORMS

IDENTIFIERS

Province : Province where material was collected

District : Name of District where BCC was collected

Place : Name of office or place where BCC was collected

Date : Date when material collected

Name : Name of the collector of BCC Material

Designation : Position on Research Team e.g. Research Assistant, Field Supervisor

BCC ATTRIBUTES

Topic : e.g. HIV/AIDS, FP/RH, Malaria, MNCH, Nutrition)

Theme : Head Title on the Material (e.g. How Many Sexual Partners do you have?)

Channel : Channel of communication e.g. Magazine, Flyer, Brochure, Sticker, Video,

Language : Language used on BCC

Audience : The target audience/population

Producer : The organisation that produced the BCC

Contact Address : Contact address of producer

Physical Address :

E-mail :

Telephone No. :

Publisher :

Sponsor(s)/Partner(s) : Sponsoring/collaborating institutions or organisations

Year : Year BCC was produced

Distributors : Distributing organisation

ISBN/Volume/Issue : International Standard Book Number

BCC MATERIAL DOCUMENTATION GUIDE

IDENTIFIERS

Province: _____

District: _____

Place: _____

Date: _____

Name of Collector: _____

Designation: _____

BCC ATTRIBUTES

Attribute	Description
Title	
Format	
Language	
Audience	
Producer	
Physical Address	
Postal Address	
Phone Number	
E-mail Address	
Publisher	
Sponsor/Partner(s)	
Year	
Distributors	
ISBN/Vol/Issue	
Description	

Appendix 6: BCC Stakeholders, their Role, Strengths and Challenges

Stakeholder/Role	Strengths	Challenges
CDC		
Covers three areas *HIV/AIDS,FP/RH &MNCH* ; Provides financial and material support; Integration of PMTCT into FP; Support HBC on HIV and TB & provides drugs	Good financial base	Due to political and economic situations sometimes funding becomes erratic.
CHAZ		
Covers two areas *HIV/AIDS & Malaria;* Community sensitisation on VCT; Provides human resources for VCT in health institutions; Distributes ITNs; Supports heart patients; Mobilises resources for malaria.	Have capacity to serve big number of patients;	Inadequate capacity to provide all households with ITNs; Inadequate transport and financial support.
CHILD FUND		
Covers two areas *HIV/AIDS & Malaria;* Training on HIV/AIDS prevention; Supports malaria prevention; Provide both finance support and capacity building; Distribute mosquito nets	Good financial base & meets with other partners	Repeats same messages in partner meetings; Do not leave reports; their services are irregular.
CIDRZ		
Covers three areas *HIV/AIDS, MNCH & Nutrition*; Capacity Building, Training; Provides food supplements in communities, formula to the babies, cooking oil & mealie meal	Works within MOH facilities; Provide incentives; Collaborates with DHMTs; Adequate technical capacities; Reaches remotest areas; Information sharing; Integration of VCT, ART, PMTC, ensuring support; Adequate funding and material support (i.e. transport)	Illiteracy, most TBA cannot read and write; lack of sustainability (donor funded right now on a phasing out process handing over to DHMT); Inadequate funding for BCC activities & Implements short term programmes only
COMMUNITY		
Utilise BCC materials. Willing to be involved in the production and other processes.		Not involved in the development of BCC processes; Inappropriate use of BCC materials by community members.

Stakeholder/Role	Strengths	Challenges
DATFs		
Covers one area *HIV/AIDS* Provide a forum on HIV/AIDS; They have structures at community level e.g. CATF	Have resources. they have formed up committees in the community; Exist in districts, full time person at district level	Inadequate transport. They depend on the MOH's for condoms; Funding is not adequate from NAC
HCP-USAID		
Covers two areas *HIV/AIDS & Malaria;* Provides HBC support; Trains the community and health centre staff on BCC materials;	Trained staff and provided materials; Had financial resources to organise staff workshops/training; Provided materials	Services were not regular and not sustained.
JICA		
Covers two areas *HIV/AIDS & MNCH;* Production/distribution of BCC materials; Material support to DHMT; Infrastructure development & Provision of supplies (e.g. CD4 machine, lab equipments, reagents) & training on HIV	Works directly with DHMT/HCs	Language barrier/most officials do not speak local language or English
MOH		
Covers all the five areas *HIV/AIDS, FP/RH, Malaria, MNCH and Nutrition;* Policy direction; Capacity Building; Coordination and Monitoring; Information dissemination; Provides material/ financial support; Provides ARVs and other supplies i.e. contraceptives & Community Education	Developed infrastructure/Systems; Availability of human Resources; Have many partners; have laboratory services	BCC needs not assessed, hence the shortages experienced; Provinces not monitored to determine targets and needs; Inadequate funding; Limited capacity to reach remotest areas; Carries out too many activities with limited results; Inadequate equipment especially for new born babies.
NHC's		
Sensitise the community; distribute the BCC materials to the community & distribute Mosquito nets to the community	Willingness to serve the community as volunteers. Live in, and are part of the community.	Erratic and delayed supplies of BCC materials at HCs and NHCs to support planned events; lack of motivation by NHCs (volunteers), Long distances / Lack of transport to HCs, lack of training, lack of incentives.
SFH		
Covers two areas *FP/RH, Malaria;* Provides/distributes FP methods e.g. condoms and contraceptive pills; Distributes ITNs/Chlorine to HCs; Provides funding	Collaborates with many partners & DHMTs; Works with the community; Adequate supply. about 95% coverage to reduce malaria cases	FP methods not accepted especially families that cherish children; Funding not consistent; Inadequate capacity provide ITNs to the community; Inadequate supplies; Inadequate transport for ITNs

UNICEF		
Covers four areas *FP/RH, Malaria, MNCH, Nutrition;* Production of BCC materials; Supply of education on contraceptives; Provide antimalarials and ITNs and chemical to use for spraying; Capacity building for staff and volunteers; Provide vaccines for MNCH; Provide drugs and equipment for delivery i.e., weighting scales; Provides BCC materials & training on logistics.	Collaboration with national food nutrition commission;	Erratic and inadequate supply of ITNs; Not regular. it takes time to provide the malaria kit; Does not reach remote areas because of transport problems due to the Geographical locations; Supply of BCC materials not consistent and inadequate; Short term programmes not sustained
USAID		
Covers one area *HIV/AIDS;* Distribution of BCC materials to their partners	Collaboration with MOH	BCC materials produced not in local languages
WHO		
Covers three areas *HIV/AIDS, FP/RH &MNCH;* Supports the country with machinery for using on VCT testing; Provides bicycles for the community workers so that they can be giving more messages to mothers on MNCH; Supports community education; Provides vaccines for those in need; Educates community on various health issues i.e, HIV and AIDS/FP.	Adequate transport to visit remote areas.	Do not know just see their name on BCC materials
World Vision		
Covers two areas *HIV/AIDS, Nutrition;* Distributing of BCC materials & Capacity Building / Training	Works with the communities; Delivers BCC materials directly to communities & Operates in hard to reach areas	Language barrier, BCC materials not produced in local language
ZISSP		
Covers all the five areas *HIV/AIDS,FP/RH, Malaria, MNCH & Nutrition*; Provide funding; Capacity building to institutions, districts, staff, volunteers & local communities i.e., on young child feeding, integrated management in childhood illness; Provide incentives to the NHCs after sensitisation meeting on malaria prevention	Adequate funding; Presence of focal point persons at Province/District	Exist at PHO, not at district and community; Operates in few districts; Community programmes have just started and have not reached all the places; Need financial support to carter all districts in the province and language barrier; BCC materials not translated in local languages

Appendix 7: Information Sheet for Participants

INFORMATION SHEET FOR PARTICIPANT

Title of Study: Development of an Inventory of Behaviour Change Communication (BCC) Materials in Zambia

Sponsors: USAID - Zambia Integrated Systems Strengthening Programme (ZISSP)

Implementer: Institute of Economic and Social Research, UNZA

The overall goal of this study is to develop an Inventory of Behaviour Change Communication (BCC) Materials in Zambia

This study will be carried out between February 27, 2012 and April 20, 2012.

Primary data will be collected from all provinces of Zambia from Ministry of Health Institutions and their surrounding communities while resource centres and libraries will be targeted for secondary data collection.

Primary data will be collected by Research Assistants from the Institute of Economic and Social Research UNZA.

BCC materials will be collected by researchers from the Ministry of Health and other identified resource canters and libraries around the country

It is a requirement that an Informed Consent Form is signed by the respondent before filling in a questionnaire.

There is no known risk in participating in this research and information collected in this study will be kept strictly confidential.

Your participation in this research is entirely voluntary, i.e. you do not have to participate if you do not wish to.

For more information or if you have questions, please contact the Research Principle Investigator

Prof. Mubiana Macwan'gi on mobile 0977 826823

Appendix 8: Informed Consent Form

INFORMED CONSENT FORM

ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAMME (ZISSP)

DEVELOPMENT OF A BEHAVIOUR CHANGE COMMUNICATION (BCC) MATERIALS INVENTORY IN ZAMBIA

Before we begin, I would like to explain why you have been invited to participate in this study and what we will be doing with the information you will provide. Please stop me at any time if you have any questions. I work at the Institute of Social and Economic Research at the University of Zambia. The Institute is conducting a study on Behaviour Change Communication. The purpose of the study is to compile the Behaviour Change Communication materials available on HIV/AIDS, Family Planning and Reproductive Health (FP/ RH), Malaria, Maternal and Newborn and Child Health (MNCH) and Nutrition.

The interview / discussion should take approximately one hour. Participation is purely voluntary. If you agree to take part in this study, l will ask you a number of questions about behaviour change communication materials. If at any time you would like to stop participating, please tell me. We can take a break, stop and continue at later date, or stop completely. You will not be penalised if you decide to stop participating at any time. However if you decide to participate in this study, I ask you to answer the questions truthfully.

There are no risks of participating in this study or direct benefits to you. However, the information we get from you will help us to inform the Zambian Ministry of Health's BCC programme implementation plans. Your participation will be kept confidential. Your name will not be written on this form, and it will be impossible to trace your responses back to you. All notes and consent forms will be stored in locked filling cabinets at INESOR, after use all data will be destroyed.

With your consent, I would like to tape record this interview so that I may better capture the details of what you will say. If you agree, you still may ask for any sensitive remarks to be withdrawn from the record and may withhold any information that you regard to be sensitive. If you wish, you are free to withdraw from the study at any time.

If you have questions, you are free to ask them now. If you have question later, you may contact me or at the number provided. If you have any questions about your rights as a participant in this research, you can contact the secretary of the Ethics Committee at the number provided below. Do you have any question at this time?

[Pause and wait of response. If there are no further questions or concerns proceed with sighing of the consent forms.]

Contact information

Principle investigator: Prof. Mubiana Macwangi

Mobile Phone Number: 0977 826823

Research Ethics Committee: Secretary

Mobile Phone Number: 0955 155633

Respondent

I have understood the conditions of participating in this study on Behaviour Change Communication and give consent to participate.

Signature/Thumb Print:_____

Date_____

Witness Signature/Thumb

Print_____Date_____